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PSYCHOTHERAPY AND LEBENSANSCHAUUNG

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THE theme of this study is quite comprehensive, and it would be easier if it were entitled something like "Psychiatry and Pastoral Care" or "Psychoanalysis and Christianity." The difficulty lies particularly in the fact that both words have so many connotations they can only with great care be distinguished from each other. Seldom has the attempt been made in the literature to separate the meanings of the two terms, and most textbooks of psychiatry and psychotherapy do not discuss the significance of the *Lebensanschauung* (philosophy of life) to both physician and patient.

The task then must be to define psychotherapy and *Lebensanschauung,* to investigate their mutual relations in theory and practice, and to show by illustrations how psychotherapy and *Lebensanschauung*—through the cooperation of physicians, psychologists and clergymen—are able to contribute to each other. I hope that such a discussion may smooth the path toward a further clarification and illumination of the problems. I cannot offer a final solution, for life is too diversified. I can, however, raise certain questions, and I believe

**Samarbejdsudvalget for Laeger og Praester*

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it will be profitable for the reader to find a personal answer.

First, the definition: psychotherapy in the strict sense is the medical treatment of diseased conditions through psychic influence based upon scientifically constructed psycho-biological principles, with the purely subjective human purpose of bringing about the cure of a diseased psychic state. The goal is to further the normal development and unfolding of the individual on the basis of his personal potentialities and bring him into bodily and spiritual harmony with himself and his environment.

It would be understandable if one should believe at the outset that psychotherapy, which like somatic medical art is anchored in biology, should halt at the border of ethics and metaphysics. But precisely because of the growing understanding of the spiritual side of the human being, as expressed in psychosomatic medicine and psychotherapy, the necessity has been emphasized of bringing into the problem area the questions of the way of life and of the *Lebensanschauung*.

Connected with this is the fact that the concept of psychotherapy has taken so many forms. The psychoanalytic schools (Freud, Adler, Jung, Bjerre, etc.) have insisted that the psychotherapist undergo several years of instruction in psychoanalysis during which the question of *Lebensanschauung* is thoroughly reviewed; indeed psychoanalysis has sometimes maintained that it is itself a *Lebensanschauung*. Danish psychiatrists, in general, do not agree with this contention, but insist that the psychotherapist be a thoroughly trained psychiatrist with special technical knowledge and comprehensive clinical experience (Reiter, Stromgren).

Just this year in Denmark, attention was called to the possibility of using the conventionally-trained practicing physician in the field of psychotherapy. This question was in fact also raised by psychiatrists (Riising, among others). Also discussed was the idea of placing academically, but not medically, trained psychotherapists—such as psychologists and perhaps clergymen—in hospitals where they could work under the guidance of physicians (Schou, Geert-Jorgensen).

Where circumstances make this possible and necessary—and this applies particularly where problems of *Lebensanschauung* come into play—there is the opportunity for collaboration between clergymen, clinical psychologists, teachers, and other persons who in their professions seek related psychotherapeutic and mental-hygienic goals. None of us can claim to possess the full truth, but we can approach it in common endeavor.

The only pre-condition for this arrangement is that the experts in the field of normal psychic life acknowledge as the physician's area of competence the field of psychic disorder and the judgment concern-

ing the total psycho-biological condition of the patient. Many symptoms, on their part, alter the psychic state much more than would be supposed from a purely psychological or pastoral consideration of the syndrome.

There is a limit which should not be exceeded. It does not suffice merely to treat symptoms when one can seize the evil at its root through diagnosis and etiological therapy. There must be a definite goal for the treatment, determined by the diagnosis as the result of which cause and effect are not confused. Within these limits, every physician, regardless of his personal *Lebensanschauung* would consider, for example, pastoral care as a very valuable aid every now and then to psychotherapy. The problems of the individual, of the patient, and his own attempts to solve them are equally meaningful to the physician as to the psychologist and the clergyman.

We have now arrived at the question of *Lebensanschauung:* the individual's subjective picture of life, his personal total view through which life receives meaning and purpose.

To possess a *Lebensanschauung* implies having found a meaningful basis for existence and being convinced of the value of life. It is, in the first place, something purely personal: an inner attitude and bearing toward life, its conditions, its values and purpose and leads to the questions of a way of life. It is an interpretation and evaluation of life, expressed socio-psychologically: the question of our attitudes, i.e., those ideas and views which contain a value-judgment combined with a distinct action or reaction inclination towards the vicissitudes of life; a psychodynamic striving towards a central point, a *modus vivendi* between the self and the environment.

In most cases such a life-view is doubtless the primary element, and the logical proofs and rational explanations with which one asserts and justifies it frequently represent merely a subsequent, often not so valuable, rational interpretation. Only few people, if indeed any, arrive at a *Lebensanschauung* through objective, abstract meditation since the emotional relation to the environment is of immeasurably greater significance and effect than the rational nexus.

Lebensanschauung is not only something subjective. There are numerous *Lebensanschauungen,* i.e., intellectual forms of several major viewpoints, which, based on the experience of a larger group of people, serve as something central and universally human. The two main illustrations are types of reality-oriented and spiritually-oriented *Lebensanschauungen,* thousands of years old. These in turn are subdivided into the naturalistic, materialistic-historical, biological, sociological, political and atheistic *Lebensanschauung* on the one hand, and the idealistic, esthetic, ethical or ethical-religious, on the other. To

the latter belong also pantheism, deism and theism, that is, the various existing religious forms including Christianity. The Christian *Lebensanschauung* can in turn be expressed in the various sects. The constituents of the *Lebensanschauung* of the individual are nowadays garnered from several of these *Lebensanschauungen,* since they are rarely found in the pure state.

We have now reached the concept of *Weltanschauung,* that is, the point of view towards the universe, its origins and its course. Our *Lebensanschauung* and our *Weltanschauung* often coincide. They may express the viewpoint towards the content and meaning of life and of all existence not only of an individual but of a nation, a community, a culture or a given historical period. In periods of breakdown, such a viewpoint may have become so necessary and valuable to a person that he will struggle to uphold it, since life seems meaningless to him without it.

The problem of psychotherapy and *Lebensanschauung* as we have now defined them are for me reduced to three basic questions:

(1) What meaning has the *Lebensanschauung* for the individual be he healthy or sick? Is it itself a sign of health or disease?

(2) Has the *Lebensanschauung* of the physician or the psychotherapist any importance in his relation to the patient and the treatment?

(3) Does psychotherapy seek to develop the *Lebensanschauung* of the patient?

The answer to the first question must be that a healthy *Lebensanschauung* is in itself an expression of psychic health. A firm *Lebensanschauung* can be an invaluable aid for attaining psychic equilibrium and stability. It can be a driving force which gives the person the energy and will to achieve a goal, a conviction that offers secure behavior-norms and a protection against the disgust for life, emptiness, and meaninglessness which the uprooted and sick experience.

This is precisely what patients complain of, that they feel inwardly homeless and insecure, that they are apathetic, and that existence no longer has any meaning. Love of life and courage are inhibited and replaced by nervous agitation and anxiety. It is a salutary deed to assist such sick persons in obtaining a central life-goal in order to overcome their destructive nihilism.

The age-old struggle between the materialistic and the spiritual *Lebensanschauung* has today been rekindled in new forms. Instinct psychology and psychotherapy are beginning to agree with the spiritual viewpoint of the clergyman in that both maintain that man has not only material, biological and social needs, but also spiritual needs whose fulfilment are of particular importance for the growth and

development of the personality. We no longer recognize the complete dominance of materialism and reason and recognize the fact that every person must find something in which he can believe even if he does not understand it by reason and which is nevertheless more unshakeable than if it were founded only on knowledge. As Goethe has already said: "Der mensch geht—durch Vernunft dividiert—nicht auf."*

Science is not the only source of knowledge at our disposal. Art, morality, and religion are three valid roads in which human life-experience lies concealed, all three of which lead to insights, truths, and inner conviction. From this it follows that the Christian *Lebensanschauung* is a health factor when it is correctly understood and assimilated.

The second question, "Has the *Lebensanschauung* of the physician or the psychotherapist any importance in his relation to the patient and the treatment?" should certainly also be answered in the affirmative.

Psychotherapy can scarcely be practiced as a purely mechanical regrouping of the psychic elements of the patient, but on the contrary, only by treating the patient from a total or basic concept of personality, does it gain assurance and force. It is true that the physician must be objective, but only a personal *Lebensanschauung* gives him that inner authority, calmness, and assurance of which the patient is unconsciously aware and which he requires in his conflict situation, even though he need not always know which particular *Lebensanschauung* the physician possesses.

Every total view of life is something positive, a source upon which the psychotherapist can draw during the treatment of the patient, not in order to suggest or to impose a *Lebensanschauung* upon the patient which the latter does not want or for which he is not ripe, but rather a basis for the psychotherapist's searching out the positive elements in his own personal *Lebensanschauung* which are useful to the particular patient and which could assist the latter to achieve a life-content which the psychotherapist unconsciously senses as his precise need.

Psychotherapy, indeed, consists in mutual interaction between two people and, therefore, the capacity for empathy, a sharp ear when questioning, knowledge of human nature, and the will to help others are more important than work with absolute magnitudes and values, even moral and religious. Ready-made pre-conceived opinions will rarely be helpful. Much more imperative is the maintenance by the patient of personal contact, which can solve so many neurotic entangle-

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*Man cannot be fully explained by reason alone.

ments, even though the contact is maintained with only one person.

Even Christian physicians and psychotherapists will therefore have to be cautious in the exercise of Christian pastoral care, necessary though it may be. The actual pastoral activity would best be left to the clergy. In answer to some such question of the patient as: "Do you personally have faith, doctor?", he should reply: "The essential factor in the treatment is not what I believe, but that I understand your problems." The minister must heed and take into consideration this approach of the physician if he himself wishes to help other people. Work with the human soul will also react upon the clergyman and the psychotherapist and contribute to the development of their personality and *Lebensanschauung*.

The third question: "Does psychotherapy seek to develop the *Lebensanschauung* of the patient and in some way give it direction?" has already been partly answered by the two foregoing questions.

We have maintained that a *Lebensanschauung* is a positive value for each person, something normal and healthy, as well as a sign that the personality is developing and gaining form. A person without a *Lebensanschauung* will often find himself incapable of helping another when the problems become acute and serious difficulties present themselves. However, from the medical point of view, the real question is not which *Lebensanschauung* the patient has, but rather *if* he has one and *if* it can bring him out of his conflicts and govern his existence. It is important therefore that the psychotherapist through a consultation receive an impression of the patient and search out the positive elements on which he can build. It will often be of greater value to restore to the individual his belief in his *Lebensanschauung* than to correct his possibly inept rational formulations.

The latter is the task of philosophy, ethics, and theology and thereby also the clergyman's. The immediate goal of psychotherapy is limited to bringing to the individual the aid which he needs at the moment, to get to the bottom of the conflict, to make use of the central and universally human elements and truths which must be taken into consideration in order to help the patient as much as possible at present and in the future. Psychotherapy is transformed therewith into psychagogy: education and self-education become a natural element of mental hygiene, a connection between the psychotherapist and the clergyman. Others must help us discover the truths which we cannot find by ourselves.

The contribution of the clergyman in this connection is in a much larger measure directly positive. The patient also expects this. Therefore I, as a clergyman, am convinced that in many difficult cases of psychic and spiritual illnesses my words and suggestions have been more acceptable and effective, particularly since they were spoken out

of personal deeply-felt experience. Moral and religious needs nearly always focus themselves, especially in psychic conflicts. There has never been a culture without religious worship and a religious need has as much real existence as other psychic needs. The final and deepest solution of the various conflicts and needs is furnished only by Christianity with its basic truth: the road to spiritual peace and faith, to a steadfastness immune to the convulsions of our times, anchored in eternal and transcendental bonds, is traversed through love, in its human manifestation incomplete and self-centered, in Jesus Christ fully formed and still effective. Such a conviction and experience is by no means out of date, but on the contrary, combined with altruistic communal striving, is the foundation for many of the most valuable *Lebensanschauungen* and integrated personalities.

Permit me in conclusion to contrast psychotherapy and *Lebensanschauung* giving several examples of practical cooperation among physicians, psychologists and clergymen as developed during the past ten to fifteen years in the United States and Northern Europe. The starting point is the recognition that the human being is a totality, a "psychobiological organism" in which the physical and mental, the healthy and the sick elements are woven into an indivisible unity which does not permit itself to be dismembered or sorted out by various individual points of view sharply differentiated from each other. Cooperation is necessary among those working with the same patient. Synthesis and group activity must go hand in hand with specialization.

In the United States, aside from hospitals in which cooperation is particularly natural and necessary, the following institutions can be mentioned: *The National Committee for Mental Hygiene; The Commission on Religion and Health,* an association on a joint church basis; *The Council for Clinical Training;* and *The Institute of Pastoral Care.* The latter two seek to instruct theological students and clergymen in the fields of psychology and psychiatry.

That the questions of *Lebensanschauung* are also included in the problem areas covered is demonstrated in the by-laws of the *Commission on Religion and Health:* "to show that health of body, mind and spirit is an essential concern of religion . . . to discover and demonstrate the distinctive place religion has in the restoration and maintenance of health . . . and to promote closer working relations of doctors and ministers . . . to improve the pastor's ministry to individuals and in institutions."

Along similar lines, although with more ecclesiastic-denominational emphasis *The Churches' Council of Healing* operates in England. It was founded in 1944 by the Archbishop of Canterbury through the amalgamation of ten different church congregations, the Guild of

Health, and other such agencies. The goal is "to afford a recognized basis for the cooperation of doctors and clergy in the study and performance of their respective functions in the work of healing, and to promote this cooperation in thought and action throughout the country . . . to establish centers of healing under adequate medical and clerical supervision." It is an attempt to continue the healing activity practiced by Christ and His apostles too long neglected by the church. Here the unity of body, mind, and soul is strongly emphasized and special healing services are held with the laying of hands on the altar, mostly with the following prayer: "May the Mercy of God, which is here present with us, now enter your soul, your mind, and your body and heal you!" This form of worship seems quite strange to us Scandinavians. The movement led to cooperation with the British Medical Association.

In Norway, a working committee of twenty physicians and twenty clergymen has been founded under the name *Kristen Hjelp* (Christian Help). Through personal and written consultation as well as through printed publications it gives advice in sexual questions, frequently also on artificial insemination. In the House of Deaconesses in Oslo a Bureau for Pastoral Care *(Sjelesorgerkontor)* has been formed and the Bishop of Oslo in March of this year, after the Danish model, has held a conference of leading physicians and hospital clergymen.

In Finland, meetings of physicians and clergymen from all over the country are held every two years. The number of participants from both sides reaches into the hundreds, the most recent meeting having taken place in June of this year in Tavestehus. *Den kristne Hjaelpecentral* (The Christian Help Centre) in Helsingfors, in which so many physicians and clergymen are active, gives advice in marital problems. The Centre places notices in the daily newspapers: "If you have decided upon a divorce, speak with us first." The director, a pastor, is now traveling all over the country in order to establish contact with physicians and clergymen.

In this field, Sweden is predominant among the Scandinavian countries. In that country, meetings of physicians and clergymen from the same provostship, the same diocese and from the entire country take place. In 1948 in Sigtuna, an intensive eight-day course was given in Psychology and Pastoral Care attended by 125 clergymen. There a comprehensive literature treating these questions from the psychiatric, psychological and pastoral point of view also exists.

St. Lukasstiftelsens institut for sjalavard och psykisk radgivning (The St. Luke Foundation for Pastoral Care and Psychological Counsel) was founded in Stockholm in 1944 and renders humanitarian, psychological, and religious aid on an ecumenical basis. The Institute is located in an ordinary three-room dwelling, but 1500 people visit it yearly to "speak to the minister." They usually have to wait from two

to three weeks for an appointment. The Institute maintains particularly close cooperation with eight physicians, and a new discipline, pastoral psychology, is developed which, on the basis of genuine Christian pastoral ministration, also handles problems of *Lebensanschauung*. The movement has an English orientation and during the past few years three or four daughter Institutes have been founded in the smaller cities.

In 1940, *Institutet for Medicinsk psykologi och psykoterapi* (Institute for Medical Psychology and Psychotherapy) was founded by the well-known psychiatrist Dr. Paul Bjerre who is oriented to the German psychoanalytic school. It practices empirical psychotherapy and offers instruction to clergymen. Although Dr. Bjerre has publicly declared himself an opponent of Christianity, he nevertheless requested that a clergyman of the state church join the staff in order to participate in the work. The clergyman works on equal terms with the psychiatrist, the neurologist, and the specialist in internal medicine, who refer certain cases to his care. The *Sallskap for pastoral-psykologi* (Society for Pastoral Psychology) which subsequently was formed seeks "to collect and analyze such experience from the field of psychological and psychotherapeutic research as will make it possible for the minister to measure up to the demands made upon him by our times."

In Denmark in 1948 the *Samarbejdsudvalget for Laeger og Praester* (Co-ordination Committee of Physicians and Clergymen) was established by the chief physicians and hospital ministers of the Roskilde diocese. It gradually established contact with other Danish physicians and clergymen, a happy sign of the times. The goal of the Committee is expressed in its four statements of objectives: (1) to further the practical cooperation and personal contacts between physicians and clergymen; (2) to utilize the theoretical knowledge as well as the practical experience which both groups have gained, for mutual instruction and for the benefit of the people whom they seek to help; (3) to be an organ for the preparation of cooperation and to represent common interests vis-a-vis corresponding groups abroad; and (4) to further the knowledge of practical psychology, mental hygiene, and Christian pastoral care among all those who deal with the sick and those afflicted with psychic conflicts.

Since the founding of the Committee two conferences have been held at which the following topics were discussed: "The Function of the Clergyman in the Hospital," "The Cooperation between Physicians and Clergymen," "The Cultural Background of the Hospital," and "Christianity in the Age of Psychology." We entertain the well-founded hope that similar common conferences of physicians and clergymen will spread over the entire country like circles in the water. During 1950, two new Coordination Committees were formed and others are being prepared in many other places.

ADOLESCENCE: THRESHOLD TO RESPONSIBILITY

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At least three major tasks confront the adolescent at a time when he is most vulnerable. His old rewards and undergirdings are being swept away from him. His accustomed skills in the art of living either are being denied him because others believe them no longer appropriate or are being abandoned by him because he has discovered for himself that they are no longer wholly successful or truly satisfying.

One of the tasks is presented to him by his own body. His growth rhythm has changed and he is forced to deal with bones, muscles, organ systems, glands, functions, and chemical conditions of varying degrees of maturity. Moreover, that growth differs in rate for each of its parts and the ratio of relative maturity among those parts shifts markedly over relatively brief intervals of time. As is any rapidly growing organism, particularly when that growth does not occur at equal rates but is asymmetrical, distorted, here fast, there slow, his body is out of balance, physiologically unstable, and both of these disequilibria bring about an emotional instability and vulnerability. Like the sick or the aging, the adolescent tends to feel inadequate when he is called upon to meet the inner and outer realities of life with a changed physiological equipment and, like them, may react with self-depreciation and sense of guilt because he feels his strength and his ego repressing and reinforcing mechanisms inadequate to control and direct the pressures being put upon him. And finally, the rapid increase in stature and change in metabolic pattern may bring about an upset in nutrition, with the result that he may lack the necessary amounts of vitamins and minerals required for optimum growth and well-being and may need to cope with some of the symptoms of deficiency disorders of greater or less magnitude.

The rapid increase of his bony structure may issue in a period of muscular incoordination, or sheer inability to handle his body and its parts and make them operate smoothly and gracefully. The old nerve-muscle-bone mass relations of childhood are destroyed and the speed of his growth spurt constantly faces him with building up new sets of relationships to fit his new size. The adolescent is, thus, faced with a problem in engineering. Along with it, he is also faced with

the need to adjust to the chemical changes going on within him and to the instinctual storms awakened by the fact that his body is now ready to act in an adult sexual manner but his emotions may still be caught in earlier familial constellations and social forces which are operating to deny him expression and gratification of his new powers. He is then left to combat not only his own inexperience and lack of knowledge but also the turmoil brought about by the increased pressure from within. This is reinforced by the added pressure which comes from frustration, no small factor in the over-all state of tension, since a drive blocked from its expression and denied an adequate substitute discharge tends to dam up and exert ever greater pressure on the inhibiting forces.

The second of the tasks facing him is that of learning to get along without the psychological nutriment of relative indulgence and support which has hitherto been his. He must now learn to find his rewards within himself, his strengths from his own store of past achievements, and at least a fair measure of his sense of integrity and right action from the consonance between his performance and his inner code. In some measure, these still come from his parents and peers and in some measure his social environment will continue to supply him with support, reward, recognition, and appreciation throughout the rest of his life. During this period of structural and anatomical disequilibrium, however, his parents and mentors are withdrawing support and making greater demands without always giving him the rewards necessary to reinforce and integrate the new and demanded skills. The adolescent is told he is no longer a child and must act like a grown-up; he is denied the same degree of gratification of his dependency needs given him earlier and deprived of some of the accustomed freedom from care and responsibility. Along with this increase in demand and decrease in support, moreover, too often in our culture his elders tend to block every attempt he makes, which are certainly bungling and inept enough in the beginning and often shaped only to failure, to act in a specifically adult manner. They call his efforts to win freedom and assume responsibility and independent action "rebellion," "impertinence," "disobedience," "foolishness." They punish him more or less severely with some chance of crippling him permanently or at least delaying his reaching the goals both he and they want: adult independence, cooperation, and responsibility both for himself and for others. He is, in other words, penalized for trying to learn to do the very thing he is asked to do and half-senses within himself that he must do.

During this time, also, he is faced with the need to free himself from his old ties, to learn to get on with his fellows, to achieve a stable set of values for himself, develop a set of standards within himself on which he can operate and on which he can stand, and

gain for himself the interior stature of a man.

His third task, then, is a social and moral one; and it is in this realm that he most often seems to bumble, get under foot, be a trial to himself, an ordeal to his elders, and a headache to everyone in his whole environment—himself included. Two of the problems presented in this area are peculiarly likely to be urgent and to be specially manifest in modes of behavior which bring him into conflict with his parents and cause them acute distress. They are the need to free himself from a set of standards, a code of behavior, a group of rules and prohibitions imposed by someone else, and to develop a cluster of his own, an interior guide for behavior, that inner watchman whom we like to call conscience; and the need to recognize and establish himself as an individual and to learn to get on with his fellows.

He must set up his own standards. So long as he merely accepts those given him by precept, admonition, or prohibition by his parents and teachers or copies those of his heroes—whether they be father, minister, or Superman, the doctor, Dick Tracy, or Howdy-Doody—he remains immature and without center or a sense of his own integrity and responsibility. For him to be safe in his own behavior, he must have an interior guide, a fixed frame of reference, a measuring stick for that which is right or wrong which is not merely a pattern, a mirrored scheme, borrowed from someone else or adopted in part or in toto from an admired examplar, but a structure which he himself has erected, accepted, and tested. To develop such a framework, he must question all that he has been told, move away from his close identification with his heroes and models, evaluate them and their right to speak, and weigh the fruits of their avowed precepts. Usually, in the end he incorporates into his own code almost everything his parents taught him, but he incorporates their teaching because he has weighed it against what he feels, what he knows, what his fellows —that is, those of his own age group—believe, what the standards and problems of his times demand. These teachings he reformulates in his own idiom. During this process, he questions, argues, tests, and comes into conflict with his parents, who too often forget that they too went through this same struggle and settled these same questions and problems for themselves in *their* own idiom and within the framework of *their* era. In doing so they maintained age-old principles, reaffirmed ancient truths, and embraced accepted standards and ideals not merely on hearsay or by virtue of the statements of authority but because they themselves found them sound and good. They too often forget that after all the old truths are valid because they are true, and that just as they once came to accept them and believe in them and fight for them and seek to uphold them and pass them on to the next generation so, in all probability, will their child.

In his second social task the adolescent meets an adversary nearer

his own size whose endowments are more nearly commensurate with his own. Yet, perhaps because of these very equalities or approximations of them, the struggle may be the more bitter and the competition and failure more able to thwart and maim. He must learn to get on with his fellows, to compete with them, to cooperate with them, to make friends with them, to learn to love and live with them. He must learn to take on his share of their responsibilities and—equally important—to let them take on their share of *his* responsibilities. He must learn to lead and to follow, to obey and to command. He must learn to submerge his immediate needs for the sake of an ultimate goal, to relinquish his desires for the sake of the common good, to accept a present compromise in the interest of a long-term value. He must learn to fight for what he believes and to know *what* he believes. He must learn to stand up for his rights and to guard the rights of others against the aggressor, and he must know what those rights are and why they are right.

To do this, he must pull away from his family and make his alliance with his own age group. For a time it may look to his elders as though he were going away completely and throwing overboard everything they have given him and tried to teach him. But this retreat and new alliance are needed because he must learn loyalty, cooperation, sharing. One can be loyal only to equals: to a superior he can merely conform, admire, or obey. The child must adhere to his family because he needs them for his security and support, for his safety and nutriment, for his very existence and its continuance; he pays them in the coin of affection and obedience. The adult can be loyal to his family because he has established himself on a comparable level with them as a responsible and responding adult; with them, on this basis, he can share, work, give, love, accept, and enjoy.

To give up dependence and attain membership, belongingness, the child must learn to become an integral part of a group. And it is in relation to this endeavor that the importance of the adolescent gang, the clique, those queer, shifting, tenuous, often puzzling alignments and friendships of the adolescent, comes into play. To test a value; to learn to cooperate; to develop acceptable measures for handling jealousy, hostility, combativeness, aggression, greed; to find out how to live with and let live; to shape a friend, one must be on equal footing, working with those whose needs are approximately the same, whose problems are comparable, whose desires approach, whose knowledge is commensurate, whose techniques coincide.

Equality of age, status, and stage of development is curiously important, crucial, and if the child misses out on one period of this social growth he can never go back and pick it up later. For some not yet adequately explained reason, even the ability to use the same language, the same slang, the same half-understood or wholly mis-

interpreted terminology, the same groping concepts, is fundamental; and if the child at seven or ten is barred from participating in the speculations, questings, theories, formulations of his fellows, he can never go back and experience them. One whole section of his path to knowledge remains unpaved. He must assume a pseudo-sophistication or have recourse to explanation by phantasy. And in one area of his life he is mal-developed; a part of his structure is distorted, flimsy, a shell; and later he may have a very difficult time repairing the damage. Sickness may cause him to lose out and deprive him of this step-by-step growing along with his peers. An over-possessive parent, a stern, repressive educational system, an over-critical mentor, and even the too-lenient, compliant, indulging parent who makes the group unnecessary or unrewarding, may spoil allegiance and block his progressive development.

All this does not mean that the parent or society are to do away with all barriers and restrictions and precepts or that the responsible adult is to stand by and let the adolescent dash headlong into danger or remain inactive while he falls into the quagmire and sinks over his head. Guidance is not license; neither is support rigid regimentation nor the extraction of blind obedience. It is not the purpose of this paper to recommend the abolishment of all barriers and the establishment of a complete *laissez faire*. Nor, from what evidence we have, does the adolescent himself wish either. The study does, however, have as one of its aims the uttering of a plea for tolerance and for a rationed, sensible freedom. In one sense it is a cry for non-possession, for understanding; it attempts a call to patience and to the realization that the chances are the child is not going to get into too much difficuly. After all, the training and love and care and precepts of ten or fourteen years have made their mark and will hold; the affection poured out on the child and returned by him will not be dissipated overnight but will persist. When he has found his feet, learned what he is, what he wants, what he can do, how to live with his equals, work with them, share with them, and take from them, he will come back and be friends with his parents. Established as a relatively secure adult, he can then accept them on a new footing, appreciate them for their real strengths instead of merely revering them because they are half-shadowy, all-powerful magical figures whom he has been taught to adore and respect, and can enjoy them because both he and they have experiences, values, principles, and goals in common and can share. But meanwhile, for a few months or years, he has to fight, to rebel, to question, to reject, to dash off into this corner and accept that ideology, to cut across social, religious, racial, geographical bounds and try out the new, to establish himself and win his place in the sun. And he must do it now, with the weapons at his command and the half-knowledge which he doesn't understand, and the fierce fire and unreasoned antipathies and sympathies burning within him.

When he is twenty-five it will be too late.

Too often in our perturbation we assume that these are problems pertinent to our era only and manifesting themselves in our culture alone. Yet the great stages of life have been succeeding each other in orderly progression ever since man was established on earth. The needs and demands of those stages have been shaping cultures and institutions and have been shaped by them ever since the beginnings of recorded time. They have peculiarity and urgency for us in part because they are present in our immediate experience and are thus poignantly real, and in part because our culture has become distorted in its growth and has tended to safeguard and indulge the needs of two age groups, the younger adult and the infant, and to ignore those of others, the adolescent and the aged.

Anthropological and psychological literature contains a great body of information about puberty and initiatory rites in other cultures and their interpretations and their intuited and observed functions. The Church has recognized the importance of the period by tending more and more to make it the traditional time for confirmation or entrance upon active church membership. The anthropologist, for example, points out that initiatory rites are always birth-and-death rites and are likely to be brought about by a ritual act of dying or of being born again into a new status in society. The process of regeneration is usually sacramental in the sense that it involves the communication of sacredness to the neophyte by means of a solemn investiture, either with insignia, garments, or other symbolic objects or by special privileges, and is accompanied by a ritual pattern of severance from the world by separation rites or vows; a union with the divine either by sacramental regeneration after fasting, endurance, ordeal, a protracted period of isolation and the observance of special taboos; a long indoctrination into the meaning of the ceremonies and the esoteric tradition; exhortation on correct social behavior and religious practice; or a ritual drama depicting these things in the life of the cult hero; and a return to society with new powers and potentialities and a higher status and greater prerogatives and responsibilities.

The psychiatrist, because of his initial orientation in illness and the need to understand and rectify malady, has tended to stress more the instinctual storms, the distortions of normal growth as the result of impenetrable barrier or distorting trauma. Only in more recent decades has he come to study these specifically as a part of a constellation of conflicting human necessities, desires, drives, and institutions. The psychologist long centered the major portion of his interest on attitudes and the best methods of inculcating and transmitting the riches, ideals, and prejudices of the existing culture. For a time, the theologian, because of external pressures brought to bear on him, was meshed in an effort to impose an ideal on a frail vessel and to preserve

the rigid form of an inherited good. In spite of the hazards and limitations placed before each by the demands of his avowed goals and the strictures of his special interests, there have always been glimpses of a wider vision in each of the three fields and men who saw beyond the immediate problem to the wider implication. Thus, we have the Church crying for centuries the isolating effect of sin and the healing within the individual and the group to be brought about by confession and public avowal of frailty; the psychologist who recognized that emotion withheld is something we conceal and that concealment leads to disturbance, isolation, and distortion, that self-restraint performed for the self and in accordance with self-determined goals and avoidances leads to ugly moods and the irritability of the "over-virtuous"; and the psychiatrist who perceived that to cherish secrets and restrain emotions within the cell of the self and its ends are psychic misdemeanors rewarded with sickness but that these things done in communion with others and for ends and ideals shared by the group could be satisfying to the individual and his fellows and strengthen both him and the group.

When a minister faces a group of adolescents, hoping to aid them in their growth and to incorporate them into the body of the church, he must first of all contend with the fact that he will be a potential threat to many of them. By some he will be perceived as a representative of the past and regarded as a force tending to hamper progress toward individuality and maturity. For others he will seem to exist not to confirm the child but to strengthen, reinforce, or replace the parents' hold over the child. And for some he will seem to exist primarily to keep the sexual side of life in the realm of phantasy and to punish its every manifestation. For yet others, he will be an exemplar, another hero to be copied, followed, rejected, doubted, tested, and later incorporated in part into the structure of the growing individual's own code and character. For these he may be the avenue from an inherited to a personal religion and the means of turning the moral issue of handling destructive desires and disruptive forces from repression and denial through restraint to control through responsibility and proper placement in a hierarchy of values.

Too often, however, the adult representatives of a culture and its institutions—of *our* culture and institutions at least—forget that the specific task of growth is the gaining of maturity and the special responsibility of the adolescent is assuming responsibility for himself and for others. We urge the adolescent toward independence and fill him with ambition and erect for him gleaming goals but forget that independence involves constructive examination of authority and the gradual moving from small responsibilities to larger ones and that the achievement of faith and strength and vision comes from the experiencing of their fruits and the rewards of purposeful, creative experience.

At the time of his confirmation the adolescent, in some groups at least, is regarded as setting his mark upon the seal placed on him at the time of his baptism and assuming full, rational, and volitional responsibility for the carrying out of the vows and commitments then made for him. By implication he is given the stature of a man in the group. Its privileges are now open to him. Its goals and values he has assumed as his own.

The Jewish boy can begin his confirmation speech with the claim *today I am a man* and have some expectation that the claim will be realized within the life of the group and the activities of the synagogue. Too often his Christian brother is made the promise but denied the fulfilment. He is told it is his duty to uphold the values of the group, contribute to their furtherance and preservation within the fellowship, and assist in their enlistment of those without the fold. It is inferred that he is to increase the health and strength of the group, but few avenues for exercising responsibility and making a contribution are open to him. After the long preparation and high anticipation of the crucial step into full membership, he too often still finds himself regarded as a troublesome, irresponsible child, someone to be watched, guarded, and, in a measure, distrusted. He is told he is to be a model for others but is given no concrete occasion for acting as a model. He is instructed to propagate his faith but is not even given the opportunity to serve as an ancillary instructor, under the trained guidance of his pastor or someone appointed by him, to the next younger age group. He might, for example, be very helpful in some sort of big-brother sponsoring relationship with some assigned member of the next confirmation class. It is conceivable that not only might instruction bite more deeply into the new candidate for membership because it is mediated by one whose difficulties had but lately been those of the confirmand and whose performance the latter can soon hope to match, but that also the sponsor's own understanding of the doctrines and practices and opportunities of his faith would be deepened and reinforced. Again, the adolescent, newly admitted to membership within his church, is urged to contribute to its finances: but his contribution gets lost in that of the whole group; he sees no recognizable results from the expenditure of the sum he has contributed with more or less willingness and more or less inconvenience to himself. He receives no recognition of his sacrifice to reinforce its continuance and is yet too young and too unskilled in the ways of life to be able to derive much satisfaction from the sense that he has done that which was expected of him and has perhaps made life easier in some unknown realm to some unknown person. It is one thing to put some money in a pledge envelope and another to work, plan, provide, and see consumed ice cream for a choir outing; it is one thing to be told one is responsible for the fabric of one's church and should pledge generously, another to earn, help select, buy, and see installed

a strip of carpet.

We learn responsibility by fulfilling responsibility. And, as in every growth process and as in every progress to mature achievement, we must go from small, concrete, fully and appropriately rewarded tasks to ever greater, more difficult, more diffuse, less tangibly rewarded and reinforced ones. In our culture, secular and religious, opportunity for the assumption, fulfilment, and recognition of responsibility for oneself and for others is not always easy to come by; a threshold is marked, a room is promised, but the door is half-barred.

SYMPTOMATOLOGY AND MANAGEMENT OF ACUTE GRIEF

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Introduction

At first glance, acute grief would not seem to be a medical or psychiatric disorder in the strict sense of the word but rather a normal reaction to a distressing situation. However, the understanding of reactions to traumatic experiences whether or not they represent clear-cut neuroses has become of ever-increasing importance to the psychiatrist. Bereavement or the sudden cessation of social interaction seems to be of special interest because it is often cited among the alleged psychogenic factors in psychosomatic disorders. The enormous increase in grief reactions due to war casualties, furthermore, demands an evaluation of their probable effect on the mental and physical health of our population.

The points to be made in this paper are as follows:

1. Acute grief is a definite syndrome with psychological and somatic symptomatology.

2. This syndrome may appear immediately after a crisis; it may be delayed; it may be exaggerated or apparently absent.

3. In place of the typical syndrome there may appear distorted pictures, each of which represents one special aspect of the grief syndrome.

4. By appropriate techniques these distorted pictures can be successfully transformed into a normal grief reaction with resolution.

Our observations comprise 101 patients. Included are (1) psychoneurotic patients who lost a relative during the course of treatment, (2) relatives of patients who died in the hospital, (3) bereaved disaster victims (Cocoanut Grove Fire) and their close relatives, (4) relatives of members of the armed forces.

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The investigation consisted of a series of psychiatric interviews. Both the timing and the content of the discussions were recorded. These records were subsequently analysed in terms of the symptoms reported and of the changes in mental status observed progressively through a series of interviews. The psychiatrist avoided all suggestions and interpretations until the picture of symptomatology and spontaneous reaction tendencies of the patients had become clear from the records. The somatic complaints offered important leads for objective study. Careful laboratory work on spirograms, g.-i. functions and metabolic studies are in progress and will be reported separately. At present we wish to present only our psychological observations.

Symptomatology of Normal Grief

The picture shown by persons in acute grief is remarkably uniform. Common to all is the following syndrome: sensations of somatic distress occurring in waves lasting from twenty minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, need for sighing, and an empty feeling in the abdomen, lack of muscular power, and an intense subjective distress described as tension or mental pain. The patient soon learns that these waves of discomfort can be precipitated by visits, by mentioning the deceased, and by receiving sympathy. There is a tendency to avoid the syndrome at any cost, to refuse visits lest they should precipitate the reaction, and to keep deliberately from thought all reference to the deceased.

The striking features are (1) the marked tendency to sighing respiration; this respiratory disturbance was most conspicuous when the patient was made to discuss his grief. (2) The complaint about lack of strength and exhaustion is universal and is described as follows: "It is almost impossible to climb up a stairway." "Everything I lift seems so heavy." "The slightest effort makes me feel exhausted." "I can't walk to the corner without feeling exhausted." (3) Digestive symptoms are described as follows: "The food tastes like sand." "I have no appetite at all." "I stuff the food down because I have to eat." "My saliva won't flow." "My abdomen feels hollow." "Everything seems slowed up in my stomach."

The sensorium is generally somewhat altered. There is commonly a slight sense of unreality, a feeling of increased emotional distance from other people (sometimes they appear shadowy or small), and there is intense preoccupation with the image of the deceased. A patient who lost his daughter in the Cocoanut Grove disaster visualized his girl in the telephone booth calling for him and was much troubled by the loudness with which his name was called by her and was so vividly preoccupied with the scene that he became oblivious of his surroundings. A young navy pilot lost a close friend; he remained a

vivid part of his imagery, not in terms of a religious survival but in terms of an imaginary companion. He ate with him and talked over problems with him, for instance, discussing with him his plan of joining the Air Corps. Up to the time of the study, six months later, he denied the fact that the boy was no longer with him. Some patients are much concerned about this aspect of their grief reaction because they feel it indicates approaching insanity.

Another strong preoccupation is with feelings of guilt. The bereaved searches the time before the death for evidence of failure to do right by the lost one. He accuses himself of negligence and exaggerates minor omissions. After the fire disaster the central topic of discussion for a young married woman was the fact that her husband died after he left her following a quarrel, and of a young man, whose wife died, that he fainted too soon to save her.

In addition, there is often disconcerting loss of warmth in relationship to other people, a tendency to respond with irritability and anger, a wish not to be bothered by others at a time when friends and relatives make a special effort to keep up friendly relationships.

These feelings of hostility, surprising and quite inexplicable to the patients, disturbed them and again were often taken as signs of approaching insanity. Great efforts are made to handle them, and the result is often a formalized, stiff manner of social interaction.

The activity throughout the day of the severely bereaved person shows remarkable changes. There is no retardation of action and speech; quite to the contrary, there is a push of speech, especially when talking about the deceased. There is restlessness, inability to sit still, moving about in an aimless fashion, continually searching for something to do. There is, however, at the same time, a painful lack of capacity to initiate and maintain organized patterns of activity. What is done is done with lack of zest, as though one were going through the motions. The bereaved clings to the daily routine of prescribed activities; but these activities do not proceed in the automatic, self-sustaining fashion which characterizes normal work but have to be carried on with effort, as though each fragment of the activity became a special task. The bereaved is surprised to find how large a part of his customary activity was done in some meaningful relationship to the deceased and has now lost its significance. Especially the habits of social interaction – meeting friends, making conversation, sharing enterprises with others—seem to have been lost. This loss leads to a strong dependency on anyone who will stimulate the bereaved to activity and serve as the initiating agent.

These five points– (1) somatic distress, (2) preoccupation with the image of the deceased, (3) guilt, (4) hostile reactions, and (5) loss of

patterns of conduct—seem to be pathognomonic for grief. There may be added a sixth characteristic, shown by patients who border on pathological reactions, which is not so conspicuous as the others but nevertheless often striking enough to color the whole picture. This is the appearance of traits of the deceased in the behavior of the bereaved, especially symptoms shown during the last illness, or behavior which may have been shown at the time of the tragedy. A bereaved person is observed or finds himself walking in the manner of his deceased father. He looks in the mirror and believes his face appears just like that of the deceased. He may show a change of interests in the direction of the former activities of the deceased and may start enterprises entirely different from his former pursuits. A wife who lost her husband, an insurance agent, found herself writing to many insurance companies offering her services with somewhat exaggerated schemes. It seemed a regular observation in these patients that the painful preoccupation with the image of the deceased described above was transformed into preoccupation with symptoms of personality traits of the lost person, but now displaced to their own bodies and activities by identification.

Course of Normal Grief Reactions

The duration of a grief reaction seems to depend upon the success with which a person does the *grief work,* namely, emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships. One of the big obstacles to this work seems to be the fact that many patients try to avoid the intense distress connected with the grief experience and to avoid the expression of emotion necessary for it. The men victims after the Cocoanut Grove fire appeared in the early psychiatric interviews to be in a state of tension with tightened facial musculature, unable to relax for fear they might "break down." It required considerable persuasion to yield to the grief process before they were willing to accept the discomfort of bereavement. One assumed a hostile attitude toward the psychiatrist, refusing to allow any references to the deceased and rather rudely asking him to leave. This attitude remained throughout his stay on the ward, and the prognosis for his condition is not good in the light of other observations. Hostility of this sort was encountered on only occasional visits with the other patients. They became willing to accept the grief process and to embark on a program of dealing in memory with the deceased person. As soon as this became possible there seemed to be a rapid relief of tension and the subsequent interviews were rather animated conversations in which the deceased was idealized and in which misgivings about the future adjustment were worked through. Examples of the psychiatrist's role in assisting patients in their readjustment after

bereavement are contained in the following case histories. The first shows a very successful readjustment.

A woman, aged 40, lost her husband in the fire. She had a history of good adjustment previously. One child, ten years old. When she heard about her husband's death she was extremely depressed, cried bitterly, did not want to live, and for three days showed a state of utter dejection.

When seen by the psychiatrist, she was glad to have assistance and described her painful preoccupation with memories of her husband and her fear that she might lose her mind. She had a vivid visual image of his presence, picturing him as going to work in the morning and herself as wondering whether he would return in the evening, whether she could stand his not returning, then, describing to herself how he does return, plays with the dog, receives his child, and gradually tried to accept the fact that he is not there any more. It was only after ten days that she succeeded in accepting his loss and then only after having described in detail the remarkable qualities of her husband, the tragedy of his having to stop his activities at the pinnacle of his success, and his deep devotion to her.

In the subsequent interviews she explained with some distress that she had become very much attached to the examiner and that she waited for the hour of his coming. This reaction she considered disloyal to her husband but at the same time she could accept the fact that it was a hopeful sign of her ability to fill the gap he had left in her life. She then showed a marked drive for activity, making plans for supporting herself and her little girl, mapping out the preliminary steps for resuming her old profession as secretary, and making efforts to secure help from the occupational therapy department in reviewing her knowledge of French.

Her convalescence, both emotional and somatic, progressed smoothly, and she made a good adjustment immediately on her return home.

A man of 52, successful in business, lost his wife, with whom he had lived in happy marriage. The information given him about his wife's death confirmed his suspicions of several days. He responded with a severe grief reaction, with which he was unable to cope. He did not want to see visitors, was ashamed of breaking down, and asked to be permitted to stay in the hospital on the psychiatric service, when his physical condition would have permitted his discharge, because he wanted further assistance. Any mention of his wife produced a severe wave of depressive reaction, but with psychiatric assistance he gradually became willing to go through this painful process, and after three days on the psychiatric service he seemed well enough to go home.

He showed a high rate of verbal activity, was restless, needed to

be occupied continually, and felt that the experience had whipped him into a state of restless overactivity.

As soon as he returned home he took an active part in his business, assuming a post in which he had a great many telephone calls. He also took over the role of amateur psychiatrist to another bereaved person, spending time with him and comforting him for his loss. In his eagerness to start anew, he developed a plan to sell all his former holdings, including his house, his furniture, and giving away anything which could remind him of his wife.

Only after considerable discussion was he able to see that this would mean avoiding immediate grief at the price of an act of poor judgment. Again he had to be encouraged to deal with his grief reactions in a more direct manner. He has made a good adjustment.

With eight to ten interviews in which the psychiatrist shares the grief work, and with a period of from four to six weeks, it was ordinarily possible to settle an uncomplicated and undistorted grief reaction. This was the case in all but one of the 13 Cocoanut Grove fire victims.

Morbid Grief Reactions

Morbid grief reactions represent distortions of normal grief. The conditions mentioned here were transformed into "normal reactions" and then found their resolution.

a. *Delay of Reaction*—The most striking and most frequent reaction of this sort is *delay* or *postponement.* If the bereavement occurs at a time when the patient is confronted with important tasks and when there is necessity for maintaining the morale of others, he may show little or no reaction for weeks or even much longer. A brief delay is described in the following example.

A girl of 17 lost both parents and her boy friend in the fire and was herself burned severely, with marked involvement of the lungs. Throughout her stay in the hospital her attitude was that of cheerful acceptance without any sign of adequate distress. When she was discharged at the end of three weeks she appeared cheerful, talked rapidly, with a considerable flow of ideas, seemed eager to return home and to assume the role of parent for her two younger siblings. Except for slight feelings of "lonesomeness" she complained of no distress.

This period of griefless acceptance continued for the next two months, even when the household was dispersed and her younger siblings were placed in other homes. Not until the end of the tenth week did she begin to show a true state of grief with marked feelings of depression, intestinal emptiness, tightness in her throat, frequent crying and vivid preoccupation with her deceased parents.

That this delay may involve years became obvious first in the fact that patients in acute bereavement about a recent death may soon upon exploration be found preoccupied with grief about a person who died many years ago. In this manner a woman of 38, whose mother had died recently and who had responded to the mother's death with a surprisingly severe reaction, was found to be but mildly concerned with her mother's death but deeply engrossed with unhappy and perplexing fantasies concerning the death of her brother, who died twenty years ago under dramatic circumstances from metastasizing carcinoma after amputation of his arm had been postponed too long. The discovery that a former unresolved grief reaction may be precipitated in the course of the discussion of another recent event was soon demonstrated in psychiatric interviews by patients who showed all the traits of a true grief reaction when the topic of a former loss arose.

The precipitating factor for the delayed reaction may be a deliberate recall of circumstances surrounding the death or may be a spontaneous occurrence in the patient's life. A peculiar form of this is the circumstance that a patient develops the grief reaction at the time when he himself is as old as the person who died. For instance, a railroad worker, aged 42, appeared in the psychiatric clinic with a picture which was undoubtedly a grief reaction for which he had no explanation. It turned out that when he was 22, his mother, then 42, had committed suicide.

b. *Distorted Reactions*—The delayed reactions may occur after an interval which was not marked by any abnormal behavior or distress, but in which there developed an *alteration* in the patient's *conduct* perhaps not conspicuous or serious enough to lead him to a psychiatrist. These alterations may be considered as the surface manifestations of an unresolved grief reaction, which may respond to fairly simple and quick psychiatric management if recognized. They may be classified as follows: (1) *overactivity without a sense of loss*, rather with a sense of well-being and zest, the activities being of an expansive and adventurous nature and bearing semblance to the activities formerly carried out by the deceased, as described above; (2) *the acquisition of symptoms belonging to the last illness of the deceased*. This type of patient appears in medical clinics and is often labelled hypochondriasis or hysteria. To what extent actual alterations of physiological functions occur under these circumstances will have to be a field of further careful inquiry. I owe to Dr. Chester Jones a report about a patient whose electrocardiogram showed a definite change during a period of three weeks, which started two weeks after the time her father died of heart disease.

While this sort of symptom formation "by identification" may still be considered as conversion symptoms such as we know from hysteria, there is another type of disorder doubtlessly presenting (3) a recognized

medical disease, namely, a group of psychosomatic conditions, predominantly ulcerative colitis, rheumatoid arthritis, and asthma. Extensive studies in ulcerative colitis have produced evidence that 33 out of 41 patients with ulcerative colitis developed their disease in close time relationship to the loss of an important person. Indeed, it was this observation which first gave the impetus for the present detailed study of grief. Two of the patients developed bloody diarrhea at funerals. In the others it developed within a few weeks after the loss. The course of the ulcerative colitis was strikingly benefited when this grief reaction was resolved by psychiatric technique.

At the level of social adjustment there often occurs a conspicuous (4) *alteration in relationship to friends and relatives.* The patient feels irritable, does not want to be bothered, avoids former social activities, and is afraid he might antagonize his friends by his lack of interest and his critical attitudes. Progressive social isolation follows, and the patient needs considerable encouragement in reestablishing his social relationships.

While overflowing hostility appears to be spread out over all relationships, it may also occur as (5) *furious hostility against specific persons;* the doctor or the surgeon are accused bitterly for neglect of duty and the patient may assume that foul play has led to the death. It is characteristic that while patients talk a good deal about their suspicions and their bitter feelings, they are not likely to take any action against the accused, as a truly paranoid person might do.

(6) Many bereaved persons struggled with much effort against these feelings of hostility, which to them seem absurd, representing a vicious change in their characters and to be hidden as much as possible. Some patients succeed in hiding their hostility but become wooden and formal, with affectivity and conduct *resembling schizophrenic pictures.* A typical report is this, "I go through all the motions of living. I look after my children, I do my errands. I go to social functions, but it is like being in a play; it doesn't really concern me. I can't have any warm feelings. If I were to have any feelings at all I would be angry with everybody." This patient's reaction to therapy was characterized by growing hostility against the therapist, and it required considerable skill to make her continue interviews in spite of the disconcerting hostility which she had been fighting so much. The absence of emotional display in this patient's face and actions was quite striking. Her face had a mask-like appearance, her movements were formal, stilted, robot-like, without the fine play of emotional expression.

(7) Closely related to this picture is a *lasting loss of patterns of social interaction.* The patient cannot initiate any activity, is full of eagerness to be active—restless, can't sleep—but throughout the day he will not start any activity unless "primed" by somebody else. He will be grateful

at sharing activities with others but will not be able to make up his mind to do anything alone. The picture is one of lack of decision and initiative. Organized activities along social lines occur only if a friend takes the patient along and shares the activity with him. Nothing seems to promise reward; only the ordinary activities of the day are carried on, and these in a routine manner, falling apart into small steps, each of which has to be carried out with much effort and without zest.

(8) There is, in addition, a picture in which a patient is active but in which most of his activities attain a coloring which is *detrimental to his own social and economic existence.* Such patients with uncalled for generosity, give away their belongings, are easily lured into foolish economic dealings, lose their friends and professional standing by a series of "stupid acts," and find themselves finally without family, friends, social status or money. This protracted self-punitive behavior seems to take place without any awareness of excessive feelings of guilt. It is a particularly distressing grief picture because it is likely to hurt other members of the family and drag down friends and business associates.

(9) This leads finally to the picture in which the grief reaction takes the form of a straight *agitated depression* with tension, agitation, insomnia, feelings of worthlessness, bitter self-accusation, and obvious need for punishment. Such patients may be dangerously suicidal.

> A young man aged 32 had received only minor burns and left the hospital apparently well on the road to recovery just before the psychiatric survey of the disaster victims took place. On the fifth day he had learned that his wife had died. He seemed somewhat relieved of his worry about her fate; impressed the surgeon as being unusually well-controlled during the following short period of his stay in the hospital.
>
> On January 1st he was returned to the hospital by his family. Shortly after his return home he had become restless, did not want to stay at home, had taken a trip to relatives trying to find rest, had not succeeded, and had returned home in a state of marked agitation, appearing preoccupied, frightened, and unable to concentrate on any organized activity. The mental status presented a somewhat unusual picture. He was restless, could not sit still or participate in any activity on the ward. He would try to read, drop it after a few minutes, or try to play pingpong, give it up after a short time. He would try to start conversations, break them off abruptly, and then fall into repeated murmured utterances: "Nobody can help me. When is it going to happen? I am doomed, am I not?" With great effort it was possible to establish enough rapport to carry on interviews. He complained about his feeling of extreme tension, inability to breathe, generalized weakness and exhaustion, and his frantic fear that something terrible was going to happen. "I'm destined to live in insanity or I must die. I know

that it is God's will. I have this awful feeling of guilt." With intense morbid guilt feelings, he reviewed incessantly the events of the fire. His wife had stayed behind. When he tried to pull her out, he had fainted and was shoved out by the crowd. She was burned while he was saved. "I should have saved her or I should have died too." He complained about being filled with an incredible violence and did not know what to do about it. The rapport established with him lasted for only brief periods of time. He then would fall back into his state of intense agitation and muttering. He slept poorly even with large sedation. In the course of four days he became somewhat more composed, had longer periods of contact with the psychiatrist, and seemed to feel that he was being understood and might be able to cope with his morbid feelings of guilt and violent impulses. On the sixth day of his hospital stay, however, after skillfully distracting the attention of his special nurse, he jumped through a closed window to a violent death.

If the patient is not conspicuously suicidal, it may nevertheless be true that he has a strong desire for painful experiences, and such patients are likely to desire shock treatments of some sort, which they picture as a cruel experience, such as electrocution might be.

A 28-year-old woman, whose 20-months-old son was accidentally smothered developed a state of severe agitated depression with self-accusation, inability to enjoy anything, hopelessness about the future, overflow of hostility against the husband and his parents, also with excessive hostility against the psychiatrist. She insisted upon electric-shock treatment and was finally referred to another physician who treated her. She responded to the shock treatments very well and felt relieved of her sense of guilt.

It is remarkable that agitated depressions of this sort represent only a small fraction of the pictures of grief in our series.

Prognostic Evaluation

Our observations indicate that to a certain extent the type and severity of the grief reaction can be predicted. Patients with obsessive personality make-up and with a history of former depressions are likely to develop an agitated depression. Severe reactions seems to occur in mothers who have lost young children. The intensity of interaction with the deceased before his death seems to be significant. It is important to realize that such interaction does not have to be of the affectionate type; on the contrary, the death of a person who invited much hostility, especially hostility which could not well be expressed because of his status and claim to loyalty, may be followed by a severe grief reaction in which hostile impulses are the most conspicuous feature. Not infrequently the person who passed away represented a key person in a social system, his death being followed by disintegra-

tion of this social system and by a profound alteration of the living and social conditions for the bereaved. In such cases readjustment presents a severe task quite apart from the reaction to the loss incurred. All these factors seem to be more important than a tendency to react with neurotic symptoms in previous life. In this way the most conspicuous forms of morbid identification were found in persons who had no former history of a tendency to psychoneurotic reactions.

Management

Proper psychiatric management of grief reactions may prevent prolonged and serious alterations in the patient's social adjustment, as well as potential medical disease. The essential task facing the psychiatrist is that of sharing the patient's grief work, namely, his efforts at extricating himself from the bondage to the deceased and at finding new patterns of rewarding interaction. It is of the greatest importance to notice that not only over-reaction but under-reaction of the bereaved must be given attention, because delayed responses may occur at unpredictable moments and the dangerous distortions of the grief reaction, not conspicuous at first, be quite destructive later, and these may be prevented.

Religious agencies have led in dealing with the bereaved. They have provided comfort by giving the backing of dogma to the patient's wish for continued interaction with the deceased, have developed rituals which maintain the patient's interaction with others, and have counteracted the morbid guilt feelings of the patient by Divine Grace and by promising an opportunity for "making up" to the deceased at the time of a later reunion. While these measures have helped countless mourners, comfort alone does not provide adequate assistance in the patient's grief work. He has to accept the pain of the bereavement. He has to review his relationships with the deceased, and has to become acquainted with the alterations in his own modes of emotional reaction. His fear of insanity, his fear of accepting the surprising changes in his feelings, especially the overflow of hostility, have to be worked through. He will have to express his sorrow and sense of loss. He will have to find an acceptable formulation of his future relationship to the deceased. He will have to verbalize his feelings of guilt, and he will have to find persons around him whom he can use as "primers" for the acquisition of new patterns of conduct. All this can be done in eight to ten interviews.

Special techniques are needed if hostility is the most marked feature of the grief reaction. The hostility may be directed against the psychiatrist, and the patient will have such guilt over his hostility that he will avoid further interviews. The help of a social worker or a minister, or if these are not available, a member of the family, to urge

the patient to continue coming to see the psychiatrist may be indispensable. If the tension and the depressive features are too great, a combination of benzedrine sulphate, 5-10 mgm. b.i.d., and sodium amytal, 3 gr. before retiring, may be useful in first reducing emotional distress to a tolerable degree. Severe agitated depressive reactions may defy all efforts of psychotherapy and may respond well to shock treatment.

Since it is obvious that not all bereaved persons, especially those suffering because of war casualties, can have the benefit of expert psychiatric help, much of this knowledge will have to be passed on to auxiliary workers. Social workers and ministers will have to be on the look-out for the more ominous pictures, referring these to the psychiatrist while assisting the more normal reactions themselves.

Anticipatory Grief Reactions

While our studies were at first limited to reactions to actual death, it must be understood that grief reactions are just one form of separation reactions. Separation by death is characterized by its irreversibility and finality. Separation may, of course, occur for other reasons. We were at first surprised to fine genuine grief reactions in patients who had not experienced a bereavement but who had experienced separation, for instance with the departure of a member of the family into the armed forces. Separation in this case is not due to death but is under the threat of death. A common picture hitherto not appreciated is a syndrome which we have designated *anticipatory grief*. The patient is so concerned with her adjustment after the potential death of father or son that she goes through all the phases of grief—depression, heightened preoccupation with the departed, a review of all the forms of death which might befall him, and anticipation of the modes of readjustment which might be necessitated by it. While this reaction may well form a safeguard against the impact of a sudden death notice, it can turn out to be of a disadvantage at the occasion of reunion. Several instances of this sort came to our attention when a soldier just returned from the battlefront complained that his wife did not love him anymore and demanded immediate divorce. In such situations apparently the grief work had been done so effectively that the patient has emancipated herself and the readjustment must now be directed towards new interaction. It is important to know this because many family disasters of this sort may be avoided through prophylactic measures.

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Many of the observations are, of course, not entirely new. Delayed reactions were described by Helen Deutsch (1). Shock treatment in

agitated depressions due to bereavement has recently been advocated by Myerson (2). Morbid identification has been stressed at many points in the psychoanalytic literature and recently by H. A. Murray (3). The relation of mourning and depressive psychoses has been discussed by Freud (4), Melanie Klein (5), and Abraham (6). Bereavement reactions in war time were discussed by Wilson (7). The reactions after the Cocoanut Grove fire were described in some detail in a chapter of the monograph of this civilian disaster (8). The effect of wartime separations was reported by Rosenbaum (9). The incidence of grief reactions among the psychogenic factors in asthma and rheumatoid arthritis has been mentioned by Cobb, *et al.* (10, 11).

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THE PARISH MINISTER'S CARE OF THE MENTALLY ILL

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THE ministry to the mentally ill has been of concern to the pastor because he has been uncertain as to what he might say or do. Recently a young pastor came to my office, and in an apologetic manner stated that he would like to visit a certain patient. He did not know whether he should visit him or not and asked guidance in arriving at a decision. The condition of this patient in the hospital was not much different from what it had been at home. In the home situation, however, the young minister had felt a little more comfortable, but in the strange environment of a mental institution he hardly knew what to expect either from the institution or from the patient. Visits to the mentally ill in the home frequently are just as disturbing for a pastor, who often feels unprepared to meet such circumstances. These distressed people have frequently been the forgotten and neglected members of the parish because of the minister's lack of understanding and uncertainty. Among the clergy, there is a growing desire to remedy this situation through a more effective ministry to the mentally ill.

Many emotional and mental conditions are embraced in the term mental illness. These disorders vary with regard to causes, symptoms, and treatments. The psychoses are the most severe type of mental illness, in which the patient is out of contact with reality. The outcome of the neuroses, which primarily disturb happiness and impair efficiency, is more hopeful. For effective pastoral care to the mentally ill the minister needs some understanding of mental disorders. He does not need a detailed technical knowledge but enough to assist him to be more capable and adequate in his ministry. Much help can be given him by the nurse and the psychiatrist in charge of the case.

The minister's resources for pastoral care of the mentally ill are unique. He has the opportunity to reveal again that the redeeming love of God never lets one go. Also, he can provide a ministry whereby the patient can be reconciled to himself, to his fellowmen, and to his God. The parishioner needs strength to meet life and relief from fear.

One of a series of lectures presented at the Pastors' Conference, Lutheran Summer School, Lakeside, Ohio, July 2-6, 1951.

Christian faith can help supply the need.

In visiting the mentally ill person, it is well to recognize him as an individual. Sometimes he has been regarded in an impersonal manner as a result of misconceptions about mental diseases. He is an individual who is sick just as any person physically ill is sick. As visits are made to the patient, his words and actions should be noted. Dr. William Allanson White, a former superintendent of St. Elizabeth's Hospital, Washington, D. C., has called our attention to the fact that through them the patient is trying to tell us something. It is at this point that the minister needs to exercise his patience and to control his anxiety so that the parishioner can convey his concerns to him. It is out of such expressions that the minister will be able to gather the emotional, social, and religious leads which will enable him to respond in an appropriate manner using the resources of pastoral care.

The pastor will need to recognize the patient's feelings of isolation, loneliness, and strangeness. Such feelings are intensified in a great degree while under institutional care and treatment. Particularly is this true in the state institution where things are even stranger, where he may not understand the treatment, and where all the new people with their sundry problems precipitate an acute sense of difference and peculiarity. There may be little privacy and this, too, is a disturbing factor. The patient feels isolated from outside contact, doors are locked, communication with friends and loved ones may be difficult. He may also feel humiliated by realizing that he is mentally ill, thinking that it is a stigma and a disgrace. Here the minister can give him assurance as he shows an understanding of the illness situation. His visit will help the parishioner realize that he has not been rejected by his pastor but that, in spite of his illness, his minister fully accepts him.

Sometime the misrepresentation of the patient's admission to an institution adds to his humiliation, even to the point of making him feel that he can no longer trust those who have been near him and are now instrumental in his institutionalization. Again he may be very resistant because he believes this to be an unwarranted commitment.

The resources of our Christian faith are to be used to give the patient the help he desires. We usually turn to religion in time of stress and strain for comfort, and he will probably desire the same. Sometimes this comfort and help is found in the visit of the minister who represents the church and the total resources of Christian faith. The use of these resources would be indicated as the need became evident. Prayer would be offered only when there is a place for it, since not all situations necessitate its use. Appropriate prayer-thoughts may be kept in mind so that the minister would be prepared. He

should be able to sense the situation so that he will know for what to pray. Religious resources should be adapted to meet individual needs. At times, their ordinary use fails to help those under great pressure. The tendency of some ministers has been to resort to them only because they feel it is the expected thing. The governing factor should be what is helpful and meaningful on the individual's own level.

A patient may be preoccupied with religion because of his own dynamic needs. This makes pastoral care rather difficult as he may cling to the minister and may desire him to agree with all that he is saying. The pastor may become fearful lest he disturb the patient if he does not agree. Persuasion will accomplish little, for often these ideas are set. The lack of dissent does not necessarily mean that the pastor agrees. Care should be exercised lest the growing feeling is conveyed that the patient is rejected because of his religious ideas. These concepts may be colored by strong feelings which, if he thinks they are being threatened by the minister, may cause him to express much anxiety or strong hostility. Here the pastor needs to listen patiently and establish rapport as well as to have some understanding of the patient's dynamic needs. Sometimes only radical psychiatric treatment will modify these concepts and then the minister, cooperating with the therapist, may have an opportunity to help direct his thinking to more wholesome levels.

While in the institution, the pastor has an opportunity to help the parishioner feel that he is not forgotten. In addition to his visits, an occasional brief pastoral letter may be helpful. Often the Sunday Church bulletins, Church school literature (Home Department Material), and daily devotional booklets are very welcome. Some may desire copies of the denominational prayer book and hymnal for devotional use. Bibles, particularly New Testaments, may be requested. The best of devotional leaflets and pamphlets are appreciated. Gift packages from the Church Auxiliaries can mean much. In making preparations for such packages it is well to check with the hospital about the contents. Such items as glass, matches, scissors, needles, razors and knives are usually forbidden since other patients might take them and harm themselves. Toilet articles and food are most acceptable. Remembrances at the various seasons, particularly at Christmas, bring much cheer. In some localities, social or city mission societies are responsible for such a ministry of remembrances. This, however, should not relieve the local pastor and congregation of their obligations to mentally ill parishioners. As a patient remarked when he had received a gift, "It is good to be remembered by my Church."

It is usually well to consider the patient's numerous complaints cautiously and not become overly alarmed or disturbed. Generally speaking, the medical and nursing staff are aware of them. Some may

have already been met, others may be exaggerated and some of them are the usual little inconveniences which one has to learn to accept. Unless the minister is aware of the situation, he may find himself an errand boy instead of a pastor. Of course, he would respond to the patient's complaints with appropriate feelings which would help the patient feel that he is not being neglected. If the personnel seem efficient and reveal a feeling of concern, the patients are generally satisfied. His complaints may be overstated.

Sometimes a mentally ill patient will refuse to see his minister. This should be accepted by the pastor as part of the illness situation. The patient's reaction may be due to several reasons. Chief among them may be his desire to escape previous environmental conditions. This may result from his hostility to the minister, stemming from the patient's feelings about what he is as an individual, what he represents in a religious sense, or his being a part of a threatening environment. To force a visit usually accomplishes little.

During the early part of the patient's recovery the minister may have an opportunity to boost his contacts with reality. If there has been a positive pastoral relationship, the minister is in a position to help support, encourage, and even stimulate him as he endeavors to make his contacts with life a bit more wholesome.

The members of the patient's family may need special attention too. Usually they are anxious and may feel guilty because they think they have not done for him what they should have from time to time and because of inadequate interpersonal relationships. They are uncertain as to the treatment and prognosis. The routine of the institution may baffle them. A splendid opportunity for pastoral service lies here.

The minister also has another opportunity to counsel with the family on the patient's return home, helping to prepare the family to receive him. Also, a share of the responsibility to bring the parishioner back into the activities of the church and help him to find a place where he can develop his sense of adequacy is his. Of course, much of this will depend upon his condition, which the minister can learn from the psychiatrist in charge. Collaboration with him at any time can be an important factor in assisting the patient to find a fuller degree of mental health.

If the minister judges the value of his ministry to the mentally ill in tangible results he may be disappointed. Results are not always obvious and things are not always what they seem. His ministry can be a fruitful experience for the parishioner through his natural warmth. This alone may be the worth of his visits.

DEVOTIONAL LITERATURE FOR PATIENTS

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THERE is an almost universal demand for devotional literature for patients in hospitals. The patients themselves ask for something religious or devotional in nature to read while they are in the hospital. The chaplains who serve the patients must meet the demand, and need something to supplement their personal ministry of pastoral counseling. Pastors in parishes feel a need for some literature to bring or send to those who are sick, and lay visitors and relatives also want something which will both satisfy the needs of the patient and make the visitor feel that he has "done something" for somebody who is somehow beyond his means of service. Frequently, doctors and nurses in the hospitals feel a need for literature to place in the hands of their patients to supplement the physical care they are able to give.

In 1942, the American Protestant Hospital Association made a survey of all Protestant hospitals to determine what sort of devotional literature was being used and received reports from sixty-two hospitals. Seward Hiltner reported the results of this survey to the Association in 1942. His report included a breakdown on the kinds of literature used, the patterns for the use of the literature, and made some constructive suggestions. His conclusion was that there was a great need for regular devotional literature to be prepared with the sick especially in mind, that such literature should be of the "religion and health" type, and that it should satisfy certain psychological needs of the patients.

As already suggested, one good reason why we should have devotional literature is because there is an almost universal demand for it. Frequently, patients, chaplains, pastors, lay visitors, doctors and nurses want it. They are not necessarily sure why they want it, or what kind they want, but they seem to have an underlying feeling there ought to be something of the sort available. Let us suggest some of the possible reasons why.

First of all, literature may be symbolic of our Christian faith. The

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Christian religion is in many respects a religion of a Book. Perhaps no other religion is so firmly grounded in the *printed word* as is ours. This is especially true of the Protestant denominations. "The Bible was the basis of the teachings of the Reformation. Luther appealed to the authority of the Bible when he challenged the power of the Pope; he appealed to the Bible when he questioned the authority of the church; the Bible furnished the powder that blasted away the mediating function of the priesthood; it was the Bible that started Luther on his revolutionary teaching of justification by faith; in the Bible the reformers discovered the right of private judgment. The Bible was the infallible rule of faith and practice."* Modern educational systems and the Sunday School were all founded in order to teach people to read so they could read the Bible. Soldiers on the battle fronts today want a copy of the Scriptures on their person because it is a symbol of their religious faith, and even though they might not read it, yet its presence tends to symbolize and make real to them the faith they believe. It is small wonder, then, that patients in the hospital who are likewise facing grave dangers and experiences that threaten their lives and challenge their faith want some copy of the Scriptures, or devotional literature, or printed word which symbolizes to them their religious faith. They may not read, but the printed word may serve as a symbol of what they have read and what they believe or want to believe.

A second reason for wanting devotional literature is similar to the first. Devotional literature is not only symbolic, but it is tangible. The cross is likewise symbolic, but many Protestants shy away from carrying one or even having one on the bedside table, where one might touch it now and then, as a Catholic patient might handle or fondle a crucifix or a rosary. The printed word is a more tangible symbol of the Protestant's faith than almost anything else. There are times when a patient may be too ill, or too disturbed, or in too awkward a position, or in too dim light, to read very much if at all, but if he has a copy of some devotional literature which he may hold in his hand, or see lying on the bedside table, or know is in the table drawer where he may get it whenever he wishes, he will possess a certain peace of mind which otherwise he might not have. Patients have often been seen going through the Operating Room and through the Post Anaesthesia Recovery Room holding in their hands devotional literature given them previously. Even though they were not able to read at such a time, the tangibility of that literature was helpful. It is evidence and reminder to them that someone who cared had been there to see them, and though the person who cared was not present physically all the time, the bit of devotional literature reminded them what

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*George A. Crapullo, *The Protestant Faith.* New York: Abingdon-Cokesbury Press, 1944, p. 14.

that friendship and concern meant.

In the third place, devotional literature is something which can be available when needed by the patient. It is probably true that nothing is so helpful or acceptable as the actual presence of the chaplain, pastor, relative, or friend at the time the patient needs spiritual support, but it is likewise true that it is impossible for them to be present every day or at all hours of the day and night. Often the patient is feeling fairly secure and confident at the time of the visit, but after the visit is over, night comes, pain increases, and loneliness steals over the patient, then he is in real need of spiritual support. If the visitor has provided him with some devotional literature, however, he can in such moments open the pages and read the message. Patients have often related how they were in misery or frightened or been restless during the night, and how the reading of something inspiring or comforting seemed to strengthen and quiet them and make the pain endurable. Anaesthetists have told of patients reading such literature while they were awaiting the time for the anaesthetic to be administered, and of how it seemed to help the patient relax and become more cooperative. Letters have been received from patients written after they returned home from the hospital, telling how the devotional literature helped them. Often patients show chaplains devotional literature their pastors have sent them or left with them after a visit, and confess their faith in its strengthening ability.

A fourth reason why devotional literature is helpful is because it may direct the thinking and feeling of the patient. This has been implied in the third reason. When a patient is fearful, or discouraged, or doubtful, or has other terrifying or frustrating feelings, reading may help to direct his thoughts toward the Source of strength and healing. Good devotional literature may help lift a patient out of his four confining walls of sickness, pain, loneliness, and self-pity into a larger world of hope and peace and worship. He may not listen to the pastor or friend telling him that there is an adequate foundation for faith in an understanding and powerful God; but sometimes he will read and remember the printed word which brings the same messages. Often chaplain, pastor, or friend may listen to a patient's account of his negative feelings of doubt and fear and never be able to help him move on to the further step of positive feelings of confidence and faith while he is there, but the literature left in the patient's hands or on his table may be able to continue where the counselor left off, and perhaps the patient can move on to the higher steps by means of the printed word read when the counselor has gone. Sometimes patients indicate that they were not much interested in the chaplain nor his literature when he first called, but afterwards picked up the devotional literature he left lying on the chair. The patient may confess that he picked up the literature, casually glanced through it

at first, then read it all and found help thereby. In such cases the chaplain may understand why he was received with gladness on the second visit when he was rejected on the first. Even though we may frown on directive counseling, yet it must be admitted that sometimes a person *is* benefited by having his thoughts and feelings directed toward more positive and hopeful realms, and such direction may helpfully come through the use of devotional literature.

Devotional literature may help the patient accept the situation in which he is placed or the condition in which he finds himself. This depends strongly upon the style and quality of the literature. Patients often ask the questions: "Why has this happened to me? What have I done to deserve such treatment from God? If God were good, kind, and just, He would not allow this to happen. I cannot believe in God any longer!" Devotional literature, if of the proper kind, may help such a person accept his situation and reconcile it with his religious faith. Under such circumstances, the patient is in desperate need of support. He may feel that his is just about the worst condition that exists. He may feel that no one understands his situation nor his reaction to it. He may believe that he should have a religious faith that will hold up under any and all trials of life, but since his has failed he may feel quite guilty—hopelessly lost. It has been found that under such circumstances devotional literature can be of help *if* it begins on the patient's level of doubt and despair, accepting him and his feelings, and avoids condemning him for his lack of faith. If he can read of others who have likewise suffered bitter blows and have felt a lack of faith in God under the despair and disappointment of the unexpected, he may not feel so alone and guilty and hopeless. Words of exhortation, example, or reassurance from the chaplain or other spiritual advisor might fall on deaf ears whereas devotional literature *of the right sort* may make itself heard.

In the sixth place, devotional literature has value to the patient in that it may be something that he can share with others. The patient is often as anxious about how relatives and friends will bear up under his circumstances of sickness or suffering as his relatives and friends are about him. Often it is the patient who must cheer up and encourage the visitor. Such patients may appreciate literature to show or send to the relatives. Patients have been known to ask the chaplain for additional copies of devotional literature "to send to my pastor and to my relatives." In addition, patients who have passed through moments of despondency and doubt and who are now feeling better may see other patients around them who are suffering the way they formerly did. They feel a strong desire to help their fellow-sufferers—and it is good for them to forget their own self-concern and pity and be interested in others—yet they may feel inadequate for the situation. It is at such a time that he would like to have something he can share

with others and say: "I felt just as you do. Here is something which helped me. If you read it, perhaps it will help you."

Finally, the use of devotional literature may help a patient verbalize his feelings to the chaplain or counselor. Patients often have feelings which they are afraid of, or unaware of, or ashamed of. They need to share them with someone to release tension and gain some insight into the meaning of the feelings. When the chaplain or religious counselor is present he may be unable to communicate because he cannot accept his feelings or is not aware of what they are. If, on the other hand, he has used some good devotional literature which helped him gain some acceptance and insight into his feelings, he may use the devotional literature as a means of starting the conversation or saying what he wants to say when the chaplain is present. Sometimes the experience is recounted like this: "Say, chaplain, I was reading that booklet you gave me, and there was something in there that says just how I feel. Perhaps you can explain it even better to me . . ." In this way the ice is broken, rapport is established, and a counseling relationship grows.

These are some of the more obvious explanations of why we need devotional literature. Let us now consider some of the factors which may be used as a guide to those who would write, publish, or distribute devotional literature.

Criteria for Good Devotional Literature

1. Size. The fact that most patients will be in bed and perhaps in a weakened condition influences the size and shape of each particular piece of devotional literature. It needs to be small so it can be held with one hand. It should be light enough not to wear the patient out with its handling. It should be fairly brief because great length might deter a patient from tackling something which might be too long to finish. It should be composed of short sections which can be read in their entirety in a few minutes because patients are not able to concentrate their attention on one thing for a very long period of time nor on very deep or complicated subject matter.

2. Make-up. Since most patients will be lying down and in poor reading light, it is essential that the size of the type be large enough to be easily read. It should be attractively printed so that it invites the reader to investigate its contents. It should be on good quality paper which will withstand much handling, falling on the floor, water being spilled on it, and so on. It should be simple in format so that it is easy for the patient to focus his attention on the contents and not have to struggle with keeping the page open or having his attention diverted to too many differing details or subjects. Its cost should be low so that it can be given, not loaned, and so the patient may not

feel guilty if it becomes damaged through handling or sick-room accidents.

3. Appropriateness. It should be literature especially prepared with the specific needs of the patient in mind. There is good devotional literature for normal, healthy individuals which leaves the patient cold or makes him feel guilty and uneasy. The spiritual needs of a patient who is in the hospital for minor surgery and a few days' incapacity are quite different from those of a patient who is to be confined for six months to a year, or perhaps for the remainder of his life. The literature for a patient with a physical illness may need to be different from that for one with a mental illness. There are some patients who are well educated and far advanced in their intellectual thinking and who would respond to quite different kinds of devotional literature from those who are unlearned or retarded. Some patients need to be challenged and encouraged to greater activity, while others need to be quieted down. Appropriate devotional literature might need to be of a different sort for each type.

4. Familiarity. The patient in the hospital is confronted with many new, strange, different procedures so that he is likely to become confused. It is well if the devotional literature contain material with which he is familiar. He should not be forced into new forms and methods of religious thinking and experience. Devotional literature should be formed, phrased, and expressed in somewhat the same manner as he is accustomed to finding in normal settings. His attention should not be so distracted by the newness or strangeness of presentation that his religious background is not allowed to be awakened and called forth into the situation.

5. Phraseology. Devotional literature should be beautiful, poetic, and easily remembered. It should be so phrased that in the night watches the patient can remember just how it read. It is well to include familiar passages of Scripture, Poetry, and Hymns. It should avoid difficult and unintelligible theological terminology. It should be simple and easily understood, yet it should avoid the trite, cliches, and the redundant. It should carefully express just what the patient would like to say. We must be careful that we do not put words in their mouths which were not in their hearts. There might be pictures, for as the Chinese proverb says, "One picture is worth a thousand words."

6. Psychological approach. One of the basic assumptions of good pastoral counseling is that the counselor should begin where the patient is. So, too, in devotional literature we should start where the patient is, not where we think he ought to be. We can be safe in assuming that he is likely to be filled with loneliness, doubt, fear, anxiety, insecurity. Instead of confronting the patient with strong positive statements of faith, confidence, and peace in such a way that we make him feel quite

guilty and even more insecure, we should start by conveying the feeling of understanding and acceptance of his negative feelings, only gradually proceeding to more positive and wholesome statements of trust, confidence, faith, reassurance.

7. Theological approach. The theological approach is difficult to describe in a way which is acceptable to all because of our differences in theology. We feel that we want to avoid presenting "Easy Salvation," yet we must not make it appear so difficult that the patient gives up in hopeless despair. We want to convey the Christian message of love and forgiveness, yet we want to avoid creating the impression that anybody can get by with almost anything. We want to express our belief of the importance of man in the order of the universe, yet we do not want to put man and God on the same level and make them equal. We must carefully choose our way between the paradoxical extremes of predestination and of perfect freedom of the will. If we consider the needs of those who are ill, however, we are likely to discover that they are generally overburdened with a sense of guilt out of all proportion to the reality of the situation. This suggests, therefore, that we might do all we can to reduce rather than increase their sense of guilt. This means, likewise, that we will avoid starting out with the assumption that everybody feels good, pure, and holy, since the probability is that most will feel evil, impure, unworthy. There are many other elements of the theological approach which need to be considered, and perhaps may suggest that we need to do more research in this field.

Conclusion

There are doubtless many other factors which should be considered in a discussion of a subject such as this. It is hoped that this will form the basis for discussion, for research, and for productivity in the field of devotional literature for the patients.

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EDITORIALS

Interprofessional Cooperation

The article by Pastor Baunbaek of Denmark is worthy of note for two reasons. First, it is well written, reveals a thorough understanding of the principles of psychotherapy on the part of a clergyman, and reflects considerable cooperation between the two professions. Second, it calls attention to the numerous interprofessional conferences and committees now existing in the Scandinavian countries. This raises the question as to how extensive is interprofessional cooperation elsewhere.

Clinical Pastoral Training as we know it—a full time, resident internship in an institution, under pastoral supervision—is probably unique in the United States. At least, we have no information about any other such programs. However, for each theological student and clergyman who is able to participate in such full time training programs, there are probably three or four who have a modified form of training in pastoral care. Institutional chaplains and theological school faculty members in a great many places conduct short courses or part time training programs as orientation to pastoral work. These range in intensity from several hours to two days each week, and extend from six weeks to a full academic year. Further, there are numerous two- three- and four-day conferences on pastoral work.

As far as we know, each of these programs includes ward observation and visitation, the recording and supervision of interviews, guided reading, and conferences, lectures and seminars. Of particular interest is the large number of professional people other than clergy who contribute to the conferences and lectures. Psychiatrists, psychologists, social workers, nurses, and occupational, recreational and industrial therapists—to name only those that come to mind most quickly—share their information and understanding about the persons entrusted to their care with the clergyman. How much the pastors contribute to the other professions is not too clear, but there are reports that nursing schools, medical schools, and training programs for psychiatrists are increasingly including lectures by clergymen trained in pastoral

care. There is no question that these developments will help each profession understand better what are the elements in any human situation common to all the "welfare" professions, and what his own unique contribution may be. And the patient or inmate will benefit.

Word recently received from other parts of the world supplements that given by Pastor Baunbaeck. In China—before the Communists took over—there was published in the Bulletin of the Council on Christian Medical Work, the report of a "Survey of Religious Work in Protestant Hospitals" made in 1947. In January of 1950 there was held a Conference on Hospital Religious Work in Shanghai, attended by fifty-two people, thirty-two of them official delegates. The three days of the Conference were devoted to lectures and discussions around such topics as: "Aims and Nature of Religious Ministry in Hospitals," "Special Methods of Ministry to the Sick," "The Worship Service in the Hospital," "Training for Religious Workers in the Hospital," and "Literature and Materials for Religious Work in Hospitals." The report concludes with the statement that all delegates felt greatly benefited by attending, and that there was organized a Fellowship of Hospital Religious and Social Workers to meet annually for further such discussions. No word has come as to whether the 1951 meeting of this Fellowship was held.

At hand, also, is a plan for three Pastoral Training Institutes for the fall of 1951, to be held at Bad Homburg vor der Höhe, Haus Taunusblick, Germany. In addition to stimulating research into better pastoral methods, it is the purpose of the Institute to provide training for pastors, deaconnesses and other parish workers, including social workers, "younger people in these professions who have already received their training and now . . . through their actual work with people are profoundly aware of their own need for deeper insights, and who are convinced that divine resources are necessary for them to fulfill their task." Each Institute is to run for four weeks, to cost about $30 (including room and board!), and to have both a theologian and a psychiatrist as regular members of the staff. The study program of the Institute is a schedule of a minimum of one hundred and fifty-two hours of seminar and discussion around such topics as "Pastoral Care," "The Structure and Life of the Parish," "Catholic and Protestant Approaches to Pastoral Care," "Nature of Personality and Personality Types," "Psychology of Youth," and "Theological and Medical Aspects of Pastoral Care."

The burden of these reports—and others regarding the establishment of chaplaincies in public institution in such countries as Canada and Australia—seems to lead to the conclusion that the clergyman and the theologian are tardy both in the recognition and acceptance of the new insights and methods developed by the other professions, and of the need for the pooling of information and resources among

the professions. The needs of the people of the parish are urgent. Whether they can be met through the church depends largely on the minister—his training, his understanding, and his ability to become a part of the therapeutic team.

F. C. K.

Reality in the Pulpit

In looking through the Sunday Service advertisements in the Saturday papers, one is impressed by the many sermon titles like these: "How to Find Peace of Mind," "How to Dispel Grief," "The Church's Answer to the Problem of Loneliness."

These sermon titles indicate that many ministers want to offer their congregations sermons which deal with the life situations in which people find themselves day after day. This effort to relate the resources of religion to the living concerns of the people is very encouraging. One wonders, however, if such titles are not often misleading.

Our desire to preach helpfully sometimes leads us to make promises which we are not able to fulfill. We may have several good insights into finding peace of mind or dispelling grief, but it is not likely that we have the *whole answer* for *each* individual in the congregation. A "This is the answer!" sermon is sure to be found wanting, while a sermon in which the title and content is dynamic and suggestive is apt to be more nearly fulfilling and less disappointing.

Without withdrawing at all from a never-ceasing search for answers, we might well accept the fact that we are still "looking through a glass darkly." A frank recognition and acceptance of this appears to be a part of whatever answer there is. Helping our people to live within the framework of reality as we find it is a part of our real task. The loneliness of Gethsemane and the agony of the Crucifixion are not simply historic incidents of the past; they are a real part of the lives of all of us. The promise of the Resurrection with its healing and fulfillment is available to all of us in this life according to our varying capacities to receive it. We must always remember, however, that the experience of new life is still like the treasure hidden in the field, and not easily found.

D. C. S.

BOOK REVIEWS

Living Your Faith: Robert Nash, S.J.; Prentice-Hall, New York, 1951. 311 pp. $3.00.

Father Nash is an Irish priest who has published a number of devotional works. This one is for a wide clientele. It achieves an almost intimate effect upon the reader, if he is a Christian by conviction, and represents a valuable piece of "bibliotherapy" for the minister in the hospital or in the parish. In a world all cluttered up with singing commercials and atom bombs, a great many confused and discouraged Christians may find strength and new order for their daily practical living by reading it.

The book falls into two parts, the first outlining the foundations of the Christian life and the second (longer) part illustrating the "know how" by pointing to episodes in the life of Jesus. It is all written in a down-to-earth and unpretentious style that gets to people "right where they live."

Somebody once defined a rich girl as a poor girl with money. Father Nash appears to define a saint as somebody for whom the Christian faith is something "they realize, whereas others only believe." This is probably the central principle of the book. The author certainly succeeds in lifting the life of our Lord out of book-covers into daily relevance. His treatment of the practice of the presence of God, which he calls "music while you work," has real moral and psychological impact. For him, as for most others of his communion, the Lay Apostolate is a reality. Inevitably, there is some use of devices peculiar to Roman Catholicism, but they do not seriously limit the book's general interest and value.

On the negative side, it is a pity that Father Nash allows himself to fall into such unnecessary blocks as a mariolatrous dedication to the Virgin "through whom we have merited to receive" Christ. The inferred doctrine of justification is a stumbling block for some Catholics and all Protestants. Many will object to his uncritical acceptance of Pere de Caussade's "sacrament of the present moment," under which it is held that anything that happens (no matter how tragic or undesirable) happens, after all, because "God has permitted it" and should therefore be accepted and utilized as a means of growth spiritually. Others will be estranged by his Creationist soul-doctrine and his serious reference to the Devil as a reality. There are also a few naive uses of the Bible, as when he says (p. 65) that "the angel asked Mary if she would freely consent to be God's Mother." Only two of the gospels have an account of the nativity. Matthew's has no mention whatever of the angel's visitation, and Luke's account of the Annunciation describes the whole matter as a *fait accompli* to which Mary merely expressed her submission.

All in all, this book represents a devotional and ascetical work far more homely and folksy than anything coming from Protestant sources, and if we want to find fault with it for any reason we shall have to earn the right to do so by getting the essentials of Christian faith to work first in our own pastoral theology.

JOSEPH F. FLETCHER

The Church and Healing: Carl. J. Scherzer; Westminster Press, Philadelphia, 1950. 272 pp. $4.00.

In the words of the author "the purpose of this book is to present a readable, comprehensive study of the influence of our Lord's spirit as it expressed itself in a ministry of healing through His Church and to show that His spirit of compassion for the sick and suffering is living in the world today." The task which Chaplain Scherzer sets himself is well executed and, to my knowledge, this book for the first time presents a chronological account of the various manifestations of the healing ministry from pre-Christian times to the present day, thereby giving a perspective from which to evaluate contemporary religious approaches to the problems of the sick.

The author himself makes no conscious attempt at criticism and evaluation of the various phases of the healing ministry as expressed historically. If the scope of the work had been broadened to include consideration of the various premises and philosophical hypotheses behind such movements in the modern period as Christian Science, New Thought and Unity, and The Emmanuel Movement, an important contribution toward correcting our present confusion as to what constitutes an acceptable Christian philosophy of healing might well have been made. *It seems* to this reviewer nothing short of marvelous that most of the fundamental presuppositions of modern psycho-somatic medicine are to be discovered in the approach of Elwood Worcester, when at almost the same period the antithesis was being promulgated by Mary Baker Eddy and the Christian Science movement. From the vantage point of our present knowledge of mind-body relationships it should be possible reasonably to differentiate between methods of healing which are sheer quackery and those consistent with the historic Christian faith. However, that is to ask of the author another type of book—one which still needs to be written. Carl Scherzer's excellent historical survey makes that next volume the more imperative.

In addition to the interesting and readable material provided in the body of this book there is at the end a comprehensive and provocative bibliography covering the entire field of the healing ministry. This book will be a stimulus to all interested in the application of Christianity to the problems of health. It opens to us an area of responsibility far broader than most of us have imagined. It is of utmost importance that the Churches and their ministry take it seriously.

ROBERT G. METTERS

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Growth in Prayer: Constance Garrett; Macmillan, New York, 1950. 156 pp. $2.00.

The title of this book might have been GROWTH THROUGH PRAYER, for its author sees prayer as never an end in itself but as a part of the individual's developing relationship with God. Miss Garrett feels that the greatest part of prayer is "knowing God and being formed by him." The occasional danger of self-centeredness from constant analysis of one's spiritual progress is offset here by the fact that the author's philosophy of prayer is consistently and emphatically God-centered. Although a dozen different kinds of prayer are discussed in detail and richly supplemented with examples, thus breaking down into its component parts the general concept of prayer, Miss Garrett does not betray her statement in the opening chapter that *to* pray is more important than *how* to pray. In her conclusion she stresses the fact that "the more we pray the less we think about kinds and ways of prayer [as] prayer becomes the background for all we do and are . . ."

The writer achieves a fine balance by presenting a wealth of detailed prayer suggestions, yet also inspiring the reader to experiment and explore in accordance

with his own level of development. Her conviction is clear that if he will but practice the life of prayer regularly and trustingly, even though awkwardly, we cannot fail—we inevitably grow. Repeated reference is made to the importance of Bible study for growth in prayer. The specific liturgical and doctrinal presuppositions throughout the twenty-one chapters may very possibly strengthen the impact of the book on those who agree with the author's theology. It might be difficult, however, for readers with a different theological background to use to the full the material presented. The book reveals the author to be a person of tremendous faith, religious sensitivity, and capacity for growth, inspiring the development of these same traits in those who read with any degree of receptivity. The style is vivid and direct, the content well within the grasp of the interested layman.

The work is thorough, practical, profound, complete. It recognizes and deals adequately with the many obstacles to a successful prayer life. It will prove of value to the religious counselor in nurturing the devotional life of his people, in revitalizing his own, and in providing effective material for sermons and for high school and adult classes.

MARJORIE DERR WILLIAMS

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The Dilemma of the Idealist: David Bryn-Jones; Macmillan, New York, 1950. 278 pp. $3.00.

Religion has been described as "the attempt to live in two worlds at the same time." One of these worlds is the familiar, here-and-now, actual world. The other is the ideal or the "real" world, in contrast to the actual world. Since these worlds coincide only in the rare moments of the mystic's peace, there is always tension between them. That tension has been steadily increasing since August, 1914. Our author, Professor of International Politics at Carleton College, deals with the perennial problem in its more recent terms. His idealist is the "uncompromising" idealist who becomes, in war time, the conscientious objector. Professor Bryn-Jones is scrupulously fair both to the solitary and prophetic moral pioneer, and to the rights of a still imperfect society. The issue is that of a working compromise between the two. This unpleasant but inevitable word is given thoughtful interpretation. Many case histories are cited: for instance that of the uncompromising idealism of Woodrow Wilson whose unwillingness to accept any reservations as to the Covenant of the League cost the world America's membership in the League. Was he right or wrong? This is by all odds much the best book on this whole subject of which I know. It gives both theoretical and practical help to the bewildered idealist in our own tragically tense time.

WILLARD L. SPERRY

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The Oxford Group: Its History and Significance: Walter H. Clark; Bookman Associates, New York, 1951. 268 pp. $3.50.

Professor Clark of Middlebury College has expanded and rewritten a doctoral dissertation presented at Harvard and has thereby produced a very interesting account of the origins and progress of the Oxford Group. The first half of the book centers around Frank Buchman himself and gives a good impression of his personal history, his characteristics, and his guiding policies. The second half is given over to case histories of some fifty-five people who answered a questionnaire about their experiences with the Group. There are two final chapters which seek to explain the influence of the Group and to estimate its value.

Taken as a whole, the book is written without malice or prejudice, and it gives evidence of careful inquiry and sympathetic appraisal. On one or two counts, however, it is not entirely satisfactory:

First, the author does not make clear whether he has had an opportunity to have discussions with or to ask questions of Frank Buchman himself. The reviewer's impression is that he has not done so, at least not recently. Second, it would appear that insufficient use has been made of the Group's own literature and of the texts of its dramatic productions. These would seem to give first-hand evidence of great importance.

Finally, the examination of the movement seems to be overweighted in favor of the earlier years of its existence. The author appears to be more familiar with developments in America than with those in England or on the Continent. A more careful analysis of the gradual change which took place in the 30's and transformed the Oxford Group into M.R.A. also constitutes a serious omission. Within these limits, however, the book may be recommended as a fair and readable account of the career of Frank Buchman and of the movement which he has so skillfully guided during the past thirty years.

F. W. DILLISTONE

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The Wings of Faith: H. V. Martin; Philosophical Library, New York, 1951. 130 pp. $2.75.

The literature dealing with Kierkegaard continues to increase. For a long time, Dr. Martin has been an eager and devoted student of his writings and this book is a consideration of the nature of Christian faith in the light of their teaching. Its central concern is to distinguish between the *What* of belief and the *How* of faith, for he believes that it was one of Kierkegaard's main achievements to shift the emphasis from the question of the content of the Christian faith to that of the way of becoming a Christian, a man of faith. In successive chapters, Dr. Martin deals with "The Problem of Christian Faith," "The Object," "The Nature and the Life of Christian Faith." The book is clear and well-arranged and can serve as a useful introduction to some of Kierkegaard's main emphases.

On the whole, however, the book is disappointing. Sometimes it travels over well-worn ground, sometimes it comes very near to doing what Kierkegaard would have been the first to condemn—making a kind of system out of his interpretation of faith. Anyone who writes about Kierkegaard ought to remind himself constantly that his master was essentially a literary artist, a critic, a satirist, a humorist, a corrective, a sufferer, as well as one who sought passionately to follow the Christ. There is little warmth and inspiration in this book. It is too analytical, too uncritical, and too extreme in one direction. It would have gained by a closer adherence to the implications of Kierkegaard's own words quoted on page 113—that a building and a buttress are interdependent and that neither can stand alone.

F. W. DILLISTONE

BOOK NOTICES

How You Grow: Bernice L. Neugarten; Science Research Associates, Chicago, 1951. 40 pp. 40 cents.

First of a Junior Life Adjustment series, this attractive booklet is aimed at providing more self-understanding for those youngsters entering upon adolescence. It

should erase much of usual confusion in children's minds as to how and why they change physically as they move towards adulthood.

Fears of Children: Helen Ross; Science Research Associates, Chicago, 1951. 48 pp. 40 cents.

This an excellent booklet for parents and teachers who must deal continually with fear in their children. The approach is constructive and reassuring.

How to Organize Your Guidance Program: Edgar L. Harden; Science Research Associates, Chicago, 1950. 70 pp. 40 cents.

This manual summarizes some new developments in school guidance practices across the country. The author outlines a step-by-step schedule for initiating, improving, and expanding the public school's guidance program. He allows for flexibility due to local conditions. Many school administrators will find the suggestions helpful. Well chosen examples of thriving guidance programs focus attention on the "whole" youth and his need for a more adequate preparation for adult living.

Adaptation: Edited by John Romano, M.D., Cornell University Press, Ithaca, New York, 1949. 113 pp. $2.00.

This little volume contains a series of five papers delivered in connection with the opening of the Psychiatric Wing of The Strong Memorial Hospital in Rochester, New York, and a brief introduction to the book itself by the editor. The papers themselves deal with the concept of adaptation from the respective viewpoints of zoology, physiology, psychobiology, psychiatry, and anthropology.

It is doubtful that the pastor will find his time well spent with this volume unless he has a special interest in technical reading.

The Quiet Way: Gerhart Tersteegen; Philosophical Library, New York, 1950. 64 pp. $1.75.

The timelessness of religious truths is again demonstrated in these selections from the letters of an eighteenth century German mystic. Tersteegen's pastoral counsel was directed towards those who were "harrassed by war-time conditions, uncongenial companions, religious doubts, bad tempers, church divisions, uncontrollable impulses, and the will to do good which seems so often to be overruled by the bent to do evil." His wisdom is equally relevant for today.

The Word Accomplished: A. B. Christopher (pseudonym); Philosophical Library, New York. 176 pp. $3.75.

On the jacket of this book the author writes, ". . . I do not feel I have the right to affix my name to 'The Word Accomplished,' as the words therein were only taken down by my hand, as a stenographer might do. And He who dictated them, was God."

To this reviewer this book appears to be something of an abortion. It seems to be a strange mixture of Naturalism, Mary Baker Eddy, a Schizophrenic, and The Prophet (Gibran)—with due apologies to all four. The author apparently attempts to make more intelligible the orthodox concepts of the Trinity, the Holy Spirit, Man, the Christ, and numerous other ideas. It has little to offer that could in any wise be considered helpful or enlightening to anyone.

GUIDE TO PERIODIC LITERATURE

Child Family Digest, April, 1951; Vol. 4, No. 4:

Working to Understand Others, by A School Staff.

This is an article from the records of a Public School in Utah which sees the working through of day by day human relationships as a part of the public school's task. Two fairly detailed accounts are offered of two grade school children who had difficulties in their relations with other students, and how the problems were handled by the staff. Suggestive material for ministers and religious educators regarding work with children.

Pastoral Psychology, March, 1951; Vol. 2, No. 12:

Anxiety from the Psychiatric Viewpoint, by Dr. Earl Bond

Dr. Bond's article on anxiety is clear and well illustrated. He seeks to deal chiefly with *neurotic* anxiety, calling it "subjective", i.e., rooted in "inner fear," as over against objective anxiety which is rooted in the external situation—such as threat from a wild animal or a car, or our competitive society, etc. This article makes "anxiety" more understandable for the minister, and thus will be a real help to those of us who are somewhat confused by the word.

Social Casework, March, 1951; Vol. XXXII, No. 3:

Helping a Tuberculous Patient to Face Surgery, by Ophelia S. Egypt.

This is an excellent article by a skillful social worker who faithfully worked with a tubercular patient through a lingering and difficult illness. The worker made careful notes on the relationship and makes them available to us in this article. The article is simply written and full of clinical material. Any minister would find an unusual amount of helpful material, particularly for work with those who are hospitalized, separated from their families, and facing operations.

Marriage and Family Living, Winter, 1951; Volume XIII, No. 1:

A Marriage Counseling Case, by Walter R. Stokes, M.D.

A brief and clear presentation of a particularly difficult marital situation in which after two years of marriage the wife was still virgin. The use of both medical and psychological techniques were offered successfully to the patient and her husband. The article is followed by stimulating and not too brief comments of a social worker, two doctors and a non-medical counselor.

D. C. S.

OUR REVIEWERS

Joseph F. Fletcher is Professor of Pastoral Theology and Christian Ethics at the Episcopal Theological School, Cambridge . . . *Robert G. Metters* is the Rector of Emmanuel Church, Boston, where the Emmanuel Movement was first started . . . *Marjorie Derr Williams* is the wife of George H. Williams of the Harvard Divinity School faculty . . . *Willard L. Sperry* is Dean of the Harvard Divinity School . . . *F. W. Dillistone* is professor of Theology at the Episcopal Theological School, Cambridge.

While we do not identify those who have written our Book Notices, we do wish to express our gratitude for their contributions.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, AND CIRCULATION REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912, AS AMENDED BY THE ACTS OF MARCH 3, 1933, AND JULY 2, 1946 (Title 39, United States Code, Section 233) OF THE JOURNAL OF PASTORAL CARE PUBLISHED QUARTERLY AT BOSTON, MASSACHUSETTS, FOR OCTOBER 1, 1951.

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FREDERICK C. KUETHER,
Business Manager.

Sworn to and subscribed before me this 1st day of October, 1951.

MARY E. SPOFFORD,
Notary Public for the State of New York. Qualified in New York County.
No. 31-3793600. Cert. filed with City Reg. N. Y. County.
My commission expires March 30, 1953.